



**ILLINOIS DEPARTMENT OF PUBLIC HEALTH**  
Office of Health Protection, Division of Infectious Diseases, HIV/AIDS Section  
**2017 HIV Prevention Interventions & Strategy Guidance**  
**for IDPH HIV Prevention Grantees**  
**Final\_01/20/2017**  
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**Agency Eligibility Criteria**

- Only organizations based within Illinois are eligible to receive HIV Prevention grant funds.
- Applicant organizations may be local health departments or not-for-profit private community-based organizations including volunteer or religious organizations which effectively engage prioritized risk populations including gay or bisexually-active males, high risk heterosexual women and men, persons who currently or formerly injected drugs, particularly those who are also transgender or racial or ethnic minorities impacted by poverty.
- Applicants must provide proof that their organizational registration with the Illinois Secretary of State is currently in good standing.
- Applicants must have paid all due County, State and Federal Taxes or have an approved payment plan in place.
- Applicants may not be a 501(c) (4) organization, or an organization whose primary mission is to engage in Illinois or federal lobbying activities.
- Applicant organizations may not have been convicted of bribing or attempting to bribe an officer or employee of the State of Illinois or any other State, nor have made an admission on the record of having so bribed or attempted to bribe (30 ILCS 500/50-5).
- If the applicant organization has been convicted of a felony, at least five years must have passed after the date of completion of the sentence for such felony, unless no person held responsible by a prosecutor's office for the facts upon which the conviction was based continues to have any involvement with the business (30 ILCS 500/50-10).
- If the applicant organization, or any officer, director, partner, or other managerial agent, has been convicted of a felony under the Sarbanes-Oxley Act of 2002, or a Class 3 or Class 2 felony under the Illinois Securities Law of 1953, at least 5 years have passed since the date of the conviction. (30 ILCS 500/50-10.5).

**Grantee Legal Requirements**

- The grantee organization and its affiliates may not be delinquent in the payment of any debt to the State (or if delinquent has entered into a deferred payment plan to pay the debt). (30 ILCS 500/50-11)
- The grantee organization may not have committed a willful or knowing violation of the Environmental Protection Act (relating to Civil Penalties under the Environmental Protection Act) within the last five (5) years. (30 ILCS 500/50-14).
- The grantee organization may not have paid any money or valuable thing to induce anyone to refrain from bidding on a State Grant, nor accepted any money or valuable thing, or acted upon the promise of same, for not bidding on a State Grant (30 ILCS 500/50-25).
- The grantee organization may not have violated the "Revolving Door" section of the Illinois Procurement Code (30 ILCS 500/50-30).

- The grantee organization may not have been convicted of the offense of bid rigging or bid rotating or any similar offense of any State or of the United States (720 ILCS 5/33E-3, 5/33E-4).
- The grantee organization may not have violated Section 50-14.5 of the Illinois Procurement Code (30 ILCCS 500/50-14.5) that states: “Owners of residential buildings who have committed a willful or knowing violation of the Lead Poisoning Prevention Act (410 ILCS 45) are prohibited from doing business with the State until the violation is mitigated”.
- The grantee organization may not be in default on an educational loan (5 ILCS 385/3).

## **Grantee Equipment Requirements**

- Grantee organizations must possess or budget to acquire computer equipment meeting the minimal technical requirements for the Department’s electronic Prevention Evaluation Monitoring System supported by Provide® Enterprise:
  - A PC computer (not Apple Macs or Unix-Based Workstations) capable of running XP, Windows Vista, or Windows 7 with all Windows Updates applied
  - An internet connection (high-speed or broadband strongly encouraged);
  - Suggested PC configuration -
    - minimal 128 MB of RAM
    - minimal Pentium 3, 600 MHz processor or equivalent
    - 8 GB hard drive
    - Super VGA or better monitor, minimum resolution 800x600, 256 colors
  - Agency Firewall opened to allow outbound TCP traffic on Port 1433
  - Administrative Access to install software on the computer
  - A document scanner connected to the computer running Provide® Enterprise with a TWAIN-compliant printer to allow the direct scanning of documents into Provide® Enterprise (rather than scanning outside of Provide® and then attaching as a file).
  - Scanner Requirements: Any type of scanner that can save scanned images to a standard format like PDF or JPG or TIF.
  - Scanner Optimal Recommendations:
    - Scanner should be direct-PC attached or network-attached to the PC where the Provide® Enterprise installation exists
    - Optional features that may be helpful include the following:
      - Duplex scanning to capture both the front and back of two-sided forms
      - A scanner accepting various document sizes and types (legal size, photo, etc.)
      - An auto-feed to capture a stack of forms

## Developing High Impact Prevention Grant Proposals

The Centers for Disease Control and Prevention (CDC) promotes the implementation of High Impact Prevention strategies and interventions to achieve the National HIV/AIDS Strategy (NHAS) 2020 goals as follow:

- Reduce the number of new HIV infections.
- Increase access to care and improve health outcomes for people living with HIV.
- Reduce HIV-related health disparities.

High-Impact Prevention (HIP) maximizes the impact of limited resources to reduce new HIV infection rates by combining cost-effective public health strategies and interventions to target the highest risk populations in the most affected geographic areas. HIP proposals incorporate strategies and interventions that meet the following criteria:

- Most cost-effective for reducing new HIV infections
- Practical to implement with target populations on a large-scale at reasonable cost
- Strategies and interventions strategically combined for greater impact

CDC estimates of cost-effectiveness by service type and risk group are listed in the table below. Programs that identify PWHIV, link them to HIV treatment, and support their HIV medication adherence have the highest impact, costing the least per new HIV infections averted. Effective behavioral interventions with PWHIV to reduce their transmission risks are the next most cost-effective, followed by behavioral interventions with prioritized high risk negatives. Biomedical interventions with prioritized risk negatives cost the most per infection averted for any given risk group, though they vary considerably by risk in cost per infection averted.

### Estimated Cost per Infection Averted in US dollars

Untargeted interventions	Cost per new infection averted		
Testing in clinical settings	\$51,000		
Partner services	\$99,000		
Linkage to care	\$115,000		
Retention in care	\$76,000		
Adherence to ART	\$43,000		
Targeted Interventions	Heterosexual	PWID	MSM
Testing in non-clinical settings	\$866,000	\$54,000	\$18,000
Behavioral intervention for HIV+ people	\$595,000	\$700,000	\$97,000
Behavioral intervention for HIV- people	\$15,600,000	\$2,900,000	\$300,000
Pre-exposure prophylaxis (PrEP)	\$170,000,000	\$900,000	\$700,000

**Source:** *High Impact HIV Prevention Services and Best Practices*, slide 19, Presentation at HIV Prevention Project Annual Technical Support Meeting, December 4, 2013, Washington, DC, Presenter, David W. Purcell, JD, PhD, Deputy Director for Behavioral and Social Science, Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention.

## **Interventions and Strategies Categories**

Interventions and Strategies may be categorized as follows:

- 1) Recruitment Strategies
- 2) Key Public Health Strategies
- 3) CDC-Supported Effective Behavioral Risk Reduction Interventions
- 4) Biomedical Risk Reduction Interventions
  - a. Evidence-Based and Evidence-Informed Linkage-Retention-Reengagement in Care (LRC) Interventions for Positives
  - b. Medication Adherence Interventions for Positives
  - c. Biomedical Risk Reduction interventions for High Risk Negatives

### **I. Recruitment Strategies**

Many interventions, in order to achieve cost effectiveness, require the targeting of groups very likely to transmit or acquire HIV infection. Strategies to selectively engage prioritized risk populations into prevention services are called recruitment strategies. *Recruitment strategies in their own right do not reduce HIV risk and are not fundable as services*, but should be used in conjunction with funded strategies and interventions to maximize the HIV prevention impact of the service. Recruitment strategies include but are not limited to the following:

- Outreach services delivered at the natural gathering sites of prioritized risk groups, that is, sites where the majority of persons gathered have the targeted risk (e.g. offering HIV testing at a methadone clinic to reach persons with injection drug use history)
- Brief pre-screening of clients at general public gathering sites in order to selectively promote prevention services to those disclosing prioritized risk while offering of condoms and literature to people who disclose lower risk behaviors
- Incentivizing target population organizations to create special social events at which prevention services occur
- Social Networking Strategy provides short-term coaching and stipends to clients with HIV-positive serostatus and/or with prioritized risk histories to recruit high risk members of their own personal social networks to participate in prevention services. For information, see <https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/PublicHealthStrategies/SocialNetworkStrategy.aspx>
- Individual-level social media recruitment via personal invitations sent through social media websites or mobile phone applications with messaging features to individuals whose profiles suggest a likely high risk behavioral history
- Risk-based advertising conveyed through websites or mobile phone applications predominantly utilized by a prioritized risk group
- Selective referrals from other providers of their clients who disclose prioritized risks

### **II. Key Public Health Strategies**

- Key Public Health Strategies may be used to target all prioritized risk, race and age groups with the following two exceptions:
  - Risk-Based HIV Testing and Referral services (RBHTR) may be used only with persons who are HIV-negative, HIV-unknown or HIV-indeterminate in serostatus.
  - Harm Reduction Counseling (HRC) including syringe exchange and overdose prevention may be provided only for persons who inject drugs (PWID).

- Risk-Based HIV Testing and Referral
  - Risk-Based HIV Testing and Referral focuses on specific populations shown to be at greater risk for acquiring HIV according to HIV surveillance or HIV testing data.
  - New CDC guidelines, “Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing in March 2016” will be implemented at the start of each new grant cycle in CY2017. The new guidelines streamline the HIV testing process by removing prevention counseling from the HIV test event and recommending linkage to treatment within 30 days of diagnosis. Available at <http://www.cdc.gov/hiv/testing/nonclinical/index.html>, the guidance also describes: HIV testing algorithms; “instant” HIV tests; couples HIV testing protocols; and recommended linkages to effective biomedical and behavioral interventions.
  - New HIV diagnoses are maximized by screening individuals disclosing risks associated with higher HIV seropositivity rates.
  - Though marketing is targeted, clients requesting testing will not be turned away even if they disclose no prioritized risks.
  - Either providers or clients may initiate testing.
  - Client level data collected includes risk history and demographic information
  - Client consent to test must be documented in the testing record and a signed release of information from the client allowing quality assurance reviews is required.
- Routine HIV Testing
  - Routine testing is recommended for all persons for HIV between the ages of 13-64 in all healthcare settings per the 2006 CDC testing guidelines and recommendations.
  - In healthcare settings which adopt routine HIV testing, all clinic patients aged 13-64 are informed they will be tested unless they decline the test and then provided an HIV test *once* as part of general medical care unless they opt out. Patients known to be at higher risk clients are recommended to have subsequent *annual* HIV testing.
  - Verbal consent is legally sufficient and must be documented in the patient’s medical record.
  - Routine testing collects risk behavior information only from clients who test HIV-positive.

### **III. CDC-Supported Behavioral Risk Reduction Interventions**

Supported interventions are cost-effective, evidence-based programs estimated by the CDC to avert HIV infections at a cost of less than \$402,000, the estimated cost of lifetime HIV treatment for one HIV-infected individual. These estimates are based on the intervention's measured risk reduction efficacy, the cost of delivering one complete intervention to one target population member, and the targeted population's estimated HIV incidence or HIV transmission rates. CDC Estimated Cost per Infection Averted for serostatus and risk groups by intervention categories are presented in the table on page 3. Specific supported interventions are listed below. As population factors are critical to these estimates, an intervention may be supported for one population but not for another. Except for possible evaluation projects, the HIV Prevention Unit does not plan to fund Behavioral Interventions which are not CDC-Supported.

- People Living With HIV (PLWH)
  - CLEAR
  - Healthy Relationships
  - Partnership for Health
  - WILLOW
  - CONNECT adapted for HIV discordant couples
  - START adapted for newly released HIV positive prisoners
- PWID
  - PROMISE
- Women
  - PROMISE
  - Sister to Sister
- MSM
  - d-up!
  - Mpowerment
  - 3MV
  - POL
  - PCC
  - PROMISE
  - VOICES/VOCES
- General Population
  - Safe in the City
- High-risk youth
  - PROMISE
- Transgender populations
  - Any of the EBIs in the CDC's Compendium of Effective Behavioral Interventions may be adapted for transgender persons



#### **IV. Biomedical Risk Reduction Interventions**

Biomedical Interventions use medical, clinical, and public health approaches designed to modify biological and physiological factors to prevent HIV infection, reduce susceptibility to HIV and/or decrease HIV infectiousness.

##### **A. Evidence-Based and Evidence-Informed Linkage-Retention-Reengagement in Care (LRC) Interventions for Positives**

Linkage-Retention-Reengagement in Care (LRC) Evidence-Based Interventions (EBIs) have been tested with a comparison group, have been rigorously evaluated, and have shown significant effects in improving linkage to, retention in, or re-engagement in HIV medical care among persons living with HIV. These interventions are considered to be scientifically rigorous and provide the strongest evidence of efficacy. LRC Evidence-Informed Interventions (EIs) have been less rigorously evaluated, but have shown some evidence of effectiveness in improving linkage to, retention in, or re-engagement in HIV medical care among persons living with HIV. The CDC has currently approved 11 LRC EBIs and EIs. Descriptions of these interventions may be found at:

<http://www.cdc.gov/hiv/prevention/research/compendium/lrc/index.html>.

As of 2016, the CDC has disseminated only one of the LRC interventions, ARTAS, as a ready-to-implement intervention with a training curriculum. Therefore, the LRC intervention prioritized for Department-funded prevention providers in 2017 is the **Antiretroviral Treatment Access Study (ARTAS)** intervention. Three other CDC-approved LRC interventions - Retention through Enhanced Personal Contacts, Extended Counseling, and STYLE – have been vetted by the Department and will be considered for prioritization after they are disseminated by the CDC as ready-to-implement LRC interventions.

##### **B. Medication Adherence Interventions for Positives**

These interventions are CDC-supported due to their effectiveness and cost-effectiveness. Adherence to anti-retroviral therapy (ART) is critical to the success of HIV treatment and treatment as prevention. However, the benefits of ART can be realized only by those individuals who are tested, diagnosed, linked promptly to medical care, start ART and adhere to achieve viral suppression. In April 2011, eight individual and group-level evidence-based interventions to support HIV medication adherence were reviewed and identified as “good-evidence” by the Centers for Disease Control & Prevention (CDC) Prevention Research Synthesis Project. The Capacity Building Branch selected four of the eight medication adherence interventions to be translated into an e-learning training toolkit for clinical and non-clinical HIV providers who serve persons living with HIV (PLWH). A fifth intervention, Pager messaging, was selected to be updated to a mobile application. These adherence interventions showed efficacy in improving either medication adherence and/or viral load reductions among either ART naïve or ART

experienced patients. These interventions are described at:

<http://www.effectiveinterventions.org/en/HighImpactPrevention/BiomedicalInterventions/MedicationAdherence.aspx#sthash.BQcQqQ4t.dpuf>

Three of these four medication adherence interventions with e-learning trainings are Department-approved for implementation in Illinois.

- 1. HEART (Helping Enhance Adherence to Antiretroviral Therapy)**
- 2. SMART Couples (Sharing Medical Adherence Responsibilities Together)**
- 3. Partnership for Health**

- *Approved targeted individuals: All HIV positive diagnosed individuals.*

The fourth – Peer Support – is duplicative of Peer Navigation Services funded by the Department’s Ryan White Program.

### **C. Biomedical Risk Reduction interventions for High Risk Negatives**

#### **1. Non-Occupational Post-Exposure Prophylaxis**

nPEP is a risk reduction method option for HIV-negative persons involving a medical referral that may be offered for a client’s consideration as individually appropriate during *any* public health strategy or risk reduction activity and documented as an activity and referral for that session.

Non-occupational Post-exposure Prophylaxis (nPEP) is the provision of antiretroviral drugs to prevent HIV infection after unanticipated sexual or injection-drug-use exposure. The *U.S. Department of Health and Human Services (DHHS) Working Group on nPEP* made the following recommendations for the United States: For persons seeking care less than 72 hours after non-occupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person known to be HIV infected, when that exposure represents a substantial risk for transmission, a 28-day course of highly active antiretroviral therapy (HAART) is recommended. Antiretroviral medications should be initiated as soon as possible after exposure. For persons seeking care more than 72 hours after non-occupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person of unknown HIV status, when such exposure would represent a substantial risk for transmission if the source were HIV infected, no recommendations are made for the use of nPEP. Clinicians should evaluate risks and benefits of nPEP on a case-by-case basis. For persons with exposure histories that represent no substantial risk for HIV transmission or who seek care more than 72 hours after exposure, DHHS does not recommend the use of nPEP. Clinicians might consider prescribing nPEP for exposures conferring a serious risk for transmission, even if the person seeks care more than 72 hours after exposure if, in their judgment, the diminished potential benefit of nPEP outweighs the risks for transmission and adverse events. For all exposures, other health risks resulting from the exposure should be considered and prophylaxis administered when indicated. Risk-reduction counseling and indicated intervention services should be provided to reduce the risk for recurrent exposures. Source: <http://www.cdc.gov/mmwr/PDF/rr/rr5402.pdf>

## 2. Pre-Exposure Prophylaxis

Pre-Exposure Prophylaxis (PrEP) is a risk reduction method option for HIV-negative persons involving a medical referral that may be offered for a client's consideration as individually appropriate during *any* public health strategy or risk reduction activity and documented as an activity and referral for that session.

PrEP is the taking of a prescribed anti-retroviral medication by an HIV-negative person prior to exposure to prevent HIV infection. The FDA has approved Truvada, combination of the drugs Emtriva and Viread, for use as PrEP.

PrEP is indicated for individuals who have a documented negative HIV test result and are at ongoing high risk for HIV infection. PrEP should only be prescribed to those who are able to adhere to the regimen and express a willingness to do so. A negative HIV test result must be confirmed as close to initiation of PrEP as possible, ideally on the day the prescription is given.

Counselors should discuss PrEP with the following non-HIV infected individuals who have substantial and ongoing risk:

- Men who have sex with men (MSM) who engage in condomless anal intercourse
- HIV negative individuals who are in a sexual relationship with a known HIV positive partner
- Male-to-Female (MTF) and Female-to-Male (FTM) transgender individuals engaging in high risk sexual behaviors
- Individuals engaging in transactional sex, such as sex for money, drugs, or housing
- People who inject drugs (PWID) who report any of the following behaviors: sharing syringes for injection purposes (including injecting hormones among transgender individuals), injecting one or more times per day, injecting cocaine or methamphetamine, engaging in high risk sexual behaviors.
- Individuals who use stimulant drugs associated with high risk behaviors, such as methamphetamine
- Individuals diagnosed with any anogenital sexually transmitted infection in the last year
- Individuals prescribed non-occupational post exposure prophylaxis (nPEP) who demonstrate continued high risk behavior or have used multiple courses of nPEP.

Medical providers must provide the testing for HIV, STIs, Hepatitis C, Kidney function and pregnancy as baselines before prescribing PrEP and subsequently at every quarterly visit.

PrEP should be discontinued by the Medical Provider under the following conditions:

- Positive HIV test result
- Renal disease development
- Use of medication for unintended purposes
- Non-adherence to medication or appointments
- Change in risk behaviors (i.e., PrEP is no longer needed)

The *IDPH PrEP Decision Counseling Guidance* provides detailed guidance on PrEP counseling, linkage and medical implementation.

## **2017 Prioritized Risk Group Definitions and Points of Consideration**

Approved at the May 20, 2016 ILHPG Meeting

### **1. HIV positive and HIV negative Men Who Have Sex with Men (MSM):**

A high-risk MSM is defined as:

- Any male (including a transgender male) aged 12 years or older who has ever had anal sex with a male (including a transgender male).

The following risk subgroup is also prioritized but solely for Health Education/Risk Reduction services:

- A same sex attracted adolescent male (SSAAM) is a potentially high-risk MSM adolescent defined as any male (including any transgender male), age 13-19 years, who reports ever having had oral sex with a male (including a transgender male) or who states he is sexually attracted to males (including transgender males).

### **2. HIV positive and HIV negative High Risk Heterosexuals (HRH):**

A HRH is defined as:

A male (including a transgender male) not meeting MSM definitions or a female (including transgender female)

- (1) who does not meet PWID definition, and
- (2) who has ever had vaginal or anal sex with someone of the other gender, and
- (3) who also discloses meeting one of the criteria below:
  - ☐ Male or Female living with HIV Disease
  - ☐ Male or Female who has ever had vaginal or anal sex with an HIV positive partner of the other sex
  - ☐ Female (including a transgender female) who ever had anal sex with a male

### **3. HIV positive and HIV negative People who Inject Drugs (PWID):**

A high-risk PWID is defined as a person of any gender who:

- does not meet the MSM definition, and
- discloses ever injecting non-prescribed drugs

### **4. HIV positive and HIV negative MSM/WID:**

A high risk HIV positive and HIV negative MSM/WID is defined as any male or transgender male who meets the definitions of both MSM and PWID who discloses:

- ever having anal sex with a male or transgender male, and
- ever injecting non-prescribed drugs

**5. HIV positive persons with “Other Risk”** are prioritized for biomedical interventions intended to link or reengage them into HIV medical treatment and to strengthen their treatment adherence:

Population Definition: HIV positive person with Other Risk is defined as a person of any gender who:

- ☐ is not known to meet the MSM, PWID, HRH, or MSM/WID definitions,
  - Never had anal sex with a male in their lifetime
  - Never had vaginal sex with a female in their lifetime
  - Never injected non-prescribed drugs in their lifetime

HIV positive persons disclosing no sexual or injection risk are not prioritized for Behavioral Interventions to reduce sexual or injection risk until such a relevant risk disclosure is made. They are prioritized for biomedical interventions until that time.

**HIV positive persons with MSM, HRH, PWID, MSM/WID or Other Risk** are prioritized for **Surveillance-Based Services** if the person:

- ☐ has been reported to IDPH HIV Surveillance as confirmed HIV+ and
- ☐ meets one of the following criteria:

- i. HIV-diagnosed within the past 12 months OR
- ii. No CD4 or VL reported within the past 12 months OR
- iii. An STI Co-infection reported within the past 12 months

**Other important points of consideration:**

- **HIV positive individuals** falling within any of the risks identified above should be a top priority within each risk category.
- **Transgender individuals** may be included within any priority population based on *personal risk history* and *current gender identification*. Transgender identity does not mean an individual engages in risk behaviors. Gender reassignment surgery should not be assumed, and unless a transgender client *opts* to disclose an operative status, risk assessment should assess sexual risks inclusive of the possibilities for male and female anatomy. Transgender females are a high priority for HIV prevention services. The positivity rate among transgender women tested by all IDPH and DASA funded project throughout Illinois between 2008 and 2013 was 1.9%, falling between the HIV seropositivity rates for African American MSM (2.8%) and Latino MSM (1.8%).
- **Persons made vulnerable** by circumstances such as incarceration or domestic violence may be prioritized in any risk group when their individual risk and biomedical histories include prioritized risks defined above.
- **Young adults** with any of the risks identified above should be prioritized within each subpopulation category.

## Strategies and Interventions for Risk-Based Grants

### Key Public Health Strategies

<b>Comprehensive Risk Counseling Services (CRCS)</b>	<b>Internet Risk Reduction Counseling (IRRC)</b>
<b>Risk-Based HIV Testing and Referral (RBHTR) with Linkage To Care (LTC)</b>	<b>Partner Services (for CBOs)</b>
<b>Harm Reduction/Syringe Exchange/Naloxone</b>	<b>Partner Services (Health Departments)</b>
<b>Hepatitis A &amp; B Vaccination</b>	<b>Surveillance-Based Services</b>
<b>Human Papilloma Virus Vaccination</b>	<b>Targeted Outreach STI Screening (Gonorrhea, Chlamydia, Syphilis)</b>
<b>Hepatitis C testing (for PWID and MSM/WID)</b>	

#### Comprehensive Risk Counseling Services (CRCS)

- CDC-approved Public Health Strategy in Risk Reduction Activity category
- Ideal for the highest at-risk clients having difficulty initiating or sustaining risk-reduction behaviors
- One-on-one 45-minute in-depth counseling sessions that include risk assessment, risk reduction plan development, multiple referrals and behavior change measurement over time
- Requires a specific training in this strategy
- *Approved targeted individuals: All prioritized populations (see pages 10-11).*

#### Risk-Based HIV Testing and Referral (RBHTR) and Linkage to Care (LTC)

- This CDC-approved Public Health Strategy is cost-effective for risk populations with 1% rate of new HIV diagnosis.
- For Department requirements for this strategy, see pages 32-34. For detailed guidance, refer to *“Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers”* (CDC, 2016). (<http://www.cdc.gov/hiv/testing/nonclinical/index.html>) The new guidelines: address HIV diagnosis as the first step in the HIV care continuum; discuss advances in HIV testing (new algorithms, “instant” HIV tests); separate prevention counseling from the HIV test event and streamline the protocol for HIV testing; highlight couple and partner HIV testing and counseling; emphasize linking high-risk HIV-negative clients to nPEP (non-occupational post-exposure prophylaxis) and PrEP (pre-exposure prophylaxis); and enhance linkage for persons living with HIV to access care and treatment within 30 days of diagnosis.
- Available testing options include FDA-approved HIV testing including both CLIA-waived point-of-care rapid tests and laboratory-processed specimens. Rapid screens may detect *solely* anti-HIV antibodies or may detect *either* anti-HIV antibodies or HIV antigens (surface proteins). Laboratory tests may include screening and supplemental testing algorithms for diagnosis confirmation which likewise may detect solely antibodies or both antibodies and antigens and which may differentiate HIV-1 from HIV-2.

- Serum specimens may be sent to the Department's Laboratory. Confirmatory Oral fluid specimens may be sent to external labs with costs reimbursed from the approved budget line.
- Referrals are individually appropriate; clients are provided with assistance in making linkages; and referrals and linkages are tracked.
- The goal is to provide HIV testing, risk assessment and referrals.
- This strategy requires a specific training. (see RBHTR Requirements)
- Linkage to Care (LTC) and Partner Services (PS) *triggered by a testing session* are parts of Risk-Based HIV Testing and Referral require no separate scopes of service. RBHTR service units awarded to an applicant agency require initiating LTC and PS for testing-identified PWHIV per IDPH HIV Testing protocols.
- *Approved targeted individuals:*  
*For RBHTR: All prioritized populations not previously diagnosed as HIV positive.*  
*For LTC: All individuals testing HIV positive.*

### **Comprehensive Harm Reduction Services –**

- This Key Public Health Strategy in the Risk Reduction Activity category includes the follow components. Provision of all three components is not required.
- **Harm Reduction Counseling**
  - One-on-one 15-20 minute counseling sessions with PWIDs to help reduce their risk for HIV and discuss proper injection techniques, vein care, hepatitis screening, and substance abuse treatment referral
  - Includes risk assessment and a risk reduction plan
- **Syringe Exchange**
  - Prevention agencies should consider providing a Comprehensive Harm Reduction Services program including legal research-linked syringe exchange. A Federal ban prohibits the use of Federal funds to purchase syringes, however Illinois General Revenue Funds may be used to purchase syringes and Federal funds may be used to support program infrastructure.
- **Naloxone**
  - Participants in Syringe Exchange Programs (SEP) are trained by SEP providers in SKOOP (Skills and Knowledge on Opiate Overdose Prevention). Trained participants receive naloxone prescription/medication at the syringe exchange program (SEP) through a standing medical order by a medical doctor.
  - *Approved targeted individuals: HIV positive and negative high risk PWID and MSM/WID of all ages, genders, races, ethnicities.*

### **Integrated Viral Hepatitis Prevention Strategies**

- These CDC-approved strategies categorized as Risk Reduction Activities include:
  - Hepatitis A Vaccination
  - Hepatitis B Vaccination
  - Hepatitis C Testing
- The Department will provide HCV rapid test kits for projects approved to test PWIDs.
- *Approved targeted individuals:*
  1. *For HAV & HBV vaccinations: all prioritized populations (See pages 10-11).*
  2. *For Hepatitis C testing: PWID and MSM/WID populations only*

## Human Papilloma Virus Vaccination

- This CDC-approved strategy is categorized as a Risk Reduction Activity.
- A complete series for either HPV4 or HPV2 consists of 3 doses. The second dose should be administered 4 to 8 weeks (minimum interval of 4 weeks) after the first dose; the third dose should be administered 24 weeks after the first dose and 16 weeks after the second dose (minimum interval of at least 12 weeks).
- *Approved Targeted Individuals:*
  - *For HPV: All prioritized populations (see pages 10-11) falling within the age, gender and serostatus criteria listed below:*
    - HPV4 for men who have sex with men through age 26 years who have received no or incomplete doses
    - Immunocompromised (including HIV infected) persons through age 26 years who have received no or incomplete doses
    - HPV vaccines are not recommended for use in pregnant women. However, pregnancy testing is not needed before vaccination. If a woman is found to be pregnant after initiating the vaccination series, no intervention is needed; the remainder of the 3-dose series should be delayed until completion of pregnancy

## Internet Risk Reduction Counseling

- This Risk Reduction Activity strategy consists of health educators conducting one-on-one risk reduction counseling sessions with high-risk individuals in internet chat rooms or mobile apps, such as Grinder, etc.
- Providers are encouraged to refer on-line clients to more intensive services such as Risk-Based HIV Testing and Referral (RBHTR) and/or Effective Behavioral Interventions.
- A separate IRRC training is required for a health educator to become certified
- *Approved targeted individuals: All prioritized populations (see pages 10-11).*

## Partner Services – for Health Departments and CBOs

- For Department requirements for this strategy, see pages 36-37.
- Partner Services (PS) involves working with newly and ongoing diagnosed HIV+ clients to elicit and then notify sex and needle sharing partners regarding their exposure to HIV and other STIs, if applicable.
- Partners of the Index Patient are offered Risk-Based HIV Testing and Referral (RBHTR) and linkage to Care services if a either a positive diagnosis is made for the partner or a prior positive diagnosis is reported by the partner.
- Partner Elicitation Interviewing ***triggered by a testing session*** is part of Risk-Based HIV Testing and Referral (RBHTR) and requires no separate scopes of service. RBHTR service units awarded to an applicant agency automatically include initiating PS for testing-identified PWHIV per IDPH RBHTR protocol.
- Specific roles are designated for Health Departments and Community Based Organizations (Non-Health Department Agencies).
- *Health Departments* may provide all steps of elicitation and notification associated with providing Partner Services including cases identified through Surveillance records.
- *Community-Based Organizations (CBOs)* shall provide services up to and including partner elicitation, but shall not provide direct notification services, unless officially



designated by the Illinois Department of Public Health. Community-based organizations do have the authority to be present during a dual notification as requested by the index patient; however, unless officially designated by the Illinois Department of Public Health, the community-based organization's role does not include direct notification of partners of positives identified through testing nor identification and direct notification of partners of positives reported through Surveillance records.

- *Approved targeted individuals: Confirmed HIV positive clients and their sex and/or injection partners.*

### **Targeted Outreach STI Screening (Gonorrhea, Chlamydia, Syphilis)**

- CDC-approved Public Health Strategy
- Risk-Based outreach STI screening (e.g., Gonorrhea, Chlamydia, and Syphilis) for persons with prioritized HIV risk histories
- IDPH provides approved collection devices for urine and venous blood specimens.
- *Approved targeted individuals: All prioritized populations.*

### **Surveillance-Based Services (SBS)**

- In this strategy, the Department refers case information to Local Health Departments (LHDs) or Designated Community-Based Organizations about confirmed HIV+ persons reported to IDPH HIV Surveillance who meet one of the following criteria:
  - **HIV-diagnosed within the past 12 months OR**
  - **No CD4 or VL reported within the past 12 months OR**
  - **An STI Co-infection reported within the past 12 months OR**
  - **Viral Load above 1,000,000 copies per milliliter or higher**
- SBS begins with an individual assessment of risk and service needs including HIV status notification, linkage or re-engagement to HIV and/or STI treatment, Partner Services, and individual level effective biomedical and/or behavioral interventions.
- *Approved targeted individuals: HIV positive persons meeting the above criteria referred by the Department to approved SBS providers.*

## Behavioral and Biomedical Risk Reduction Interventions

<b>CLEAR-for PWHIV</b>	<b>Mpowerment</b>
<b>Community PROMISE</b>	<b>Personal Cognitive Counseling (PCC)</b>
<b>CONNECT-for Serodiscordant</b>	<b>Popular Opinion Leader (POL)</b>
<b>d-up: Defend Yourself!</b>	<b>Project START-for PWHIV</b>
<b>Healthy Relationships</b>	<b>Safe in the City</b>
<b>LRC Interventions (includes ARTAS)</b>	<b>Sister to Sister</b>
<b>Many Men, Many Voices (3MV)</b>	<b>TWISTA</b>
<b>Medication Adherence Interventions</b>	<b>WILLOW</b>

Interventions are services provided to people in an effort to decrease their risk of acquiring or transmitting HIV. The US Centers for Disease Control and Prevention (CDC) has identified interventions that research has shown to be *effective*, that is, reducing risk behavior, and others that meet its raised standard of *cost-effectiveness*, that is, preventing enough infections per dollar invested to justify public funds investment. Grant Monitors and Lead Agencies should prioritize funding providers already prepared to conduct cost-effective interventions for a prioritized population in a given area whenever possible.

### **Behavioral Risk Reduction Interventions**

#### **CLEAR**

- This intervention is effective and cost-effective for PWHIV.
- This intervention is effective for high risk HIV-negative persons, but CDC-unsupported due to weak cost-effectiveness for this population.
- CLEAR is a health promotion intervention for men and women 16 and older living with HIV and high-risk HIV-negative individuals.
- CLEAR is a client-centered intervention delivered one-on-one using cognitive behavioral techniques to change behaviors. CLEAR can be effectively integrated into a program's CRCS activities.
- Requires a separate training for certification.
- *Approved targeted individuals: HIV positive and negative high risk MSM, HRH, PWID, and MSM/WID ages 16 and older, of all ages, genders, races and ethnicities.*

#### **Community PROMISE**

- This intervention is effective and cost-effective for all prioritized risk populations.
- Peers Reaching Out and Modeling Intervention Strategies (PROMISE)
- An effective, community-level intervention that relies on role model stories and peer advocates from the community
- A community identification process obtains role model stories from individuals of target populations who have made positive behavior change.
- Requires a separate training for certification.
- This is an integrated intervention for 2017, which means that the CDC has incorporated biomedical components into the intervention. Please visit

<https://effectiveinterventions.cdc.gov/en/WhatsNew.aspx> to access the integrated curriculum.

- All service providers must utilize the integrated curricula when delivering integrated EBIs.
- *Approved targeted individuals: HIV positive and negative high risk MSM, HRH, PWID, and MSM/WID of all ages, genders, races and ethnicities.*

## **CONNECT**

- This intervention is effective and cost-effective for HIV-serodiscordant heterosexual couples.
- CONNECT is a six-session, relationship-based intervention that teaches heterosexual couples techniques and skills to enhance the quality of their relationship, communication, and shared commitment to safer behaviors.
- CONNECT integrates techniques commonly used in family therapy to allow couples to work together to solve shared problems.
- CONNECT targets heterosexual women and men ages 18 and over and their main sexual partners.
- The intervention requires training for certification.
- This is an integrated intervention for 2017, which means that the CDC has incorporated biomedical components into the intervention. Please visit <https://effectiveinterventions.cdc.gov/en/WhatsNew.aspx> to access the integrated curriculum.
- All service providers must utilize the integrated curricula when delivering integrated EBIs.
- *Approved targeted individuals: HIV positive and negative high risk HRH (male and female) ages 18 and older of all races and ethnicities, and their partners.*

## **d-up: Defend Yourself!**

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- d-up! is a cultural adaptation of the Popular Opinion Leader (POL) intervention and is designed to change social norms and perceptions of black MSM regarding condom use.
- d-up! specifically targets black MSM who are in social networks with other black MSM. Opinion leaders change risky sexual norms in these networks.
- Requires a separate training for certification.
- *Approved targeted individuals: HIV positive and negative high risk black MSM of all ages.*

## **Healthy Relationships**

- This intervention is rated effective and cost-effective.
- The intervention is a five-session small group program for men and women living with HIV.
- Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure and behavior.
- Role plays, movie clips are utilized in group work.
- Requires separate training for certification.

- *Approved targeted individuals: HIV positive high risk MSM, HRH, PWID, and MSM/WID ages 18 and older of all genders, races and ethnicities.*

### **Many Men, Many Voices (3MV)**

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- A seven-session group-level intervention to prevent HIV and STDs among adult black men who have sex with men (MSM).
- The intervention addresses culture, social and religious norms, sexual relationship dynamics and other topics.
- Requires a separate training for certification.
- This is an integrated intervention for 2017, which means that the CDC has incorporated biomedical components into the intervention. Please visit <https://effectiveinterventions.cdc.gov/en/WhatsNew.aspx> to access the integrated curriculum.
- All service providers must utilize the integrated curricula when delivering integrated EBIs.
- *Approved targeted individuals: HIV negative high risk black MSM ages 18 and older.*

### **Mpowerment**

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- A community-level intervention designed for young MSM, ages 18-29.
- The intervention is run by young MSM from the community and is based at an Mpowerment “drop-in center”.
- The intervention includes small and large community events, safer sex group discussions, a media campaign, and peer-led community outreach.
- Requires a separate training for certification.
- This is an integrated intervention for 2017, which means that the CDC has incorporated biomedical components into the intervention. Please visit <https://effectiveinterventions.cdc.gov/en/WhatsNew.aspx> to access the integrated curriculum.
- All service providers must utilize the integrated curricula when delivering integrated EBIs.
- *Approved targeted individuals: HIV positive and negative high risk MSM ages 18-29.*

### **Personal Cognitive Counseling (PCC)**

- This test counseling protocol is CDC-supported due to its effectiveness and cost-effectiveness.
- PCC is an individual-level, single session counseling intervention designed to reduce high risk sexual behaviors among men who have sex with men (MSM) who are repeat testers for HIV
- Requires a separate training for certification.
- This is an integrated intervention for 2017, which means that the CDC has incorporated biomedical components into the intervention. Please visit

<https://effectiveinterventions.cdc.gov/en/WhatsNew.aspx> to access the integrated curriculum.

- All service providers must utilize the integrated curricula when delivering integrated EBIs.
- *Approved targeted individuals: HIV negative high risk MSM of all ages, races, and ethnicities.*

### **Popular Opinion Leader (POL)**

- This intervention is CDC-supported for MSM including MSM/WID due to its effectiveness and cost-effectiveness.
- This intervention is effective, but CDC-unsupported for HRH and PWID due to weak cost-effectiveness.
- Involves identifying and training “popular opinion leaders” to provide HIV prevention messages and support to peers in specific social networks.
- Goal is to change community norms about HIV prevention.
- Requires separate training for certification.
- This is an integrated intervention for 2017, which means that the CDC has incorporated biomedical components into the intervention. Please visit <https://effectiveinterventions.cdc.gov/en/WhatsNew.aspx> to access the integrated curriculum.
- All service providers must utilize the integrated curricula when delivering integrated EBIs.
- *Approved targeted individuals: HIV positive and negative MSM, HRH, PWID, and MSM/WID of all ages, genders, races and ethnicities.*

### **Project START**

- This intervention is CDC-supported only as adapted for HIV+ Persons due to its effectiveness and cost-effectiveness.
- This intervention is effective but CDC-unsupported for HIV-negative incarcerated persons, due to weak cost-effectiveness.
- Project START is a multi-session intervention for people being released from a correctional facility and returning to the community. Two sessions are provided with the client before release and four sessions after release.
- The intervention is based on the framework of incremental risk reduction and focuses on increasing clients’ awareness of their sexual and drug use risk behaviors after release and providing them with tools and resources to reduce their risk.
- The intervention requires training for certification.
- This is an integrated intervention for 2017, which means that the CDC has incorporated biomedical components into the intervention. Please visit <https://effectiveinterventions.cdc.gov/en/WhatsNew.aspx> to access the integrated curriculum.
- All service providers must utilize the integrated curricula when delivering integrated EBIs.
- *Approved targeted individuals: HIV positive and negative high risk MSM, HRH, PWID, and MSM/WID of all ages, genders, races and ethnicities being released from a correctional facility.*

### **Safe in the City**

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- A 23-minute HIV/STD prevention video for STD clinic waiting rooms that has been shown to be effective in reducing STDs among racially diverse groups of STD clinic patients.
- Safe in the City aims to increase condom use and other safe sex behaviors among HRH and MSM populations of varying races.
- *Approved targeted individuals: HIV positive and negative high risk MSM, HRH, of all ages, genders, races and ethnicities.*

### **Sister to Sister**

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- Sister to Sister is a brief (20-minute) one-on-one, skills-based HIV/STD risk-reduction behavioral intervention for sexually active African-American women 18 to 45 years old that is delivered during the course of a routine medical visit.
- The intervention is highly structured must be implemented in a *primary health care setting* by nurses, health educators or other professional clinical staff using videos, brainstorming, experiential exercises, and skills-building activities.
- Sister to Sister requires training for certification.
- This is an integrated intervention for 2017, which means that the CDC has incorporated biomedical components into the intervention. Please visit <https://effectiveinterventions.cdc.gov/en/WhatsNew.aspx> to access the integrated curriculum.
- All service providers must utilize the integrated curricula when delivering integrated EBIs.
- *Approved targeted individuals: HIV positive and negative sexually active black high risk HRH (female) ages 18 -45.*

### **TWISTA**

- TWISTA is an adaptation of the effective behavioral group-level intervention SISTA modified for high-risk African-American transgender MTF.
- TWISTA is delivered in five two-hour sessions emphasizing transgender and ethnic pride.
- Requires a separate training for certification.
- *Approved targeted individuals: HIV positive and negative black high risk transgender MTF ages 18 and above.*

### **VOICES/VOCES -Video Opportunities for Innovative Condom Education and Safer Sex**

- This intervention *when used with MSM* is CDC-supported due to its effectiveness and cost-effectiveness.
- This intervention requires training for certification.
- An STD-clinic based group prevention intervention for African-American and Latino MSM.

- The intervention is delivered in one 45-minute session with gender-specific groups of 4-8 clinic patients by playing a video and beginning a condom discussion/distributing condoms.
- *Approved targeted individuals: HIV positive and negative black and Hispanic high risk MSM ages 18 and above.*

## **WILLOW**

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- WILLOW is a social-skills building and educational intervention for adult heterosexual women 18-50 years old of any race living with HIV.
- An adaptation of the SISTA intervention, emphasizing gender pride, WILLOW consists of 4 four-hour small group sessions delivered by two trained adult female facilitators, one of whom is a woman living with HIV.
- Peer led intervention for women who are HIV positive led by women who are HIV positive
- WILLOW requires training for certification.
- This is an integrated intervention for 2017, which means that the CDC has incorporated biomedical components into the intervention. Please visit <https://effectiveinterventions.cdc.gov/en/WhatsNew.aspx> to access the integrated curriculum.
- All service providers must utilize the integrated curricula when delivering integrated EBIs.
- *Approved targeted individuals: HIV positive female high risk HRH ages 18 -50.*

## **Biomedical Risk Reduction Interventions**

Biomedical Interventions use medical, clinical, and public health approaches designed to moderate biological and physiological factors to prevent HIV infection, reduce susceptibility to HIV and/or decrease HIV infectiousness.

### **A. Evidence-Based and Evidence-Informed Linkage-Retention-Reengagement in Care (LRC) Interventions for Positives**

Linkage-Retention-Reengagement in Care (LRC) Evidence-Based Interventions (EBIs) have been tested with a comparison group, have been rigorously evaluated, and have shown significant effects in improving linkage to, retention in, or re-engagement in HIV medical care among persons living with HIV. These interventions are considered to be scientifically rigorous and provide the strongest evidence of efficacy. LRC Evidence-Informed Interventions (EIs) have been less rigorously evaluated, but have shown some evidence of effectiveness in improving linkage to, retention in, or re-engagement in HIV medical care among persons living with HIV. The CDC has currently approved 11 LRC EBIs and EIs. Descriptions of these interventions may be found at:

<http://www.cdc.gov/hiv/prevention/research/compendium/lrc/index.html>.

As of 2016, the CDC has disseminated only one of the LRC interventions, ARTAS, as a ready-to-implement intervention with a training curriculum. Therefore, the LRC intervention prioritized for Department-funded prevention providers in-2017 is the **Antiretroviral Treatment Access Study (ARTAS)** intervention. Three other CDC-approved LRC interventions - Retention through Enhanced Personal Contacts, Extended Counseling, and STYLE – have been vetted by the Department and will be considered for prioritization after they are disseminated by the CDC as ready-to-implement LRC interventions.

## **ARTAS**

- Anti-Retroviral Treatment and Access to Services (ARTAS) is a CDC-supported LRC evidence-based, individual-level, multi-session, time-limited intervention delivered by HIV Case Managers to link individuals who have been recently diagnosed with HIV to medical care.
- ARTAS consists of up to five client sessions conducted over a 90 day period or until the client links to medical care – whichever comes first. Eligible clients should be within 6–12 months of receiving an HIV-positive diagnosis.
- During the client sessions, the Linkage Coordinator builds a relationship with the client. The client, focusing on his/her self-identified strengths, creates an action plan (known as the ARTAS Session Plan) with specific goals, including linking to medical care. Not every client will move sequentially through the five sessions nor will every client complete all five sessions.
- *Approved targeted individuals: Individuals who received an HIV positive diagnosis within the last 12 months.*

## **B. Medication Adherence Interventions for Positives**

These interventions are CDC-supported due to their cost-effectiveness. Adherence to anti-retroviral therapy (ART) is critical to optimizing health outcomes for persons living with HIV and to treatment as prevention. However, the benefits of ART can be realized only by those individuals who are tested, diagnosed, promptly linked to medical care, and who start and adhere to ART to achieve viral suppression. In April 2011, eight individual and group-level evidence-based interventions to support HIV medication adherence were reviewed and identified as “good-evidence” by the Centers for Disease Control & Prevention (CDC) Prevention Research Synthesis Project. The Capacity Building Branch selected four of the eight medication adherence interventions to be translated into an e-learning training toolkit for clinical and non-clinical HIV providers who serve persons living with HIV (PLWH). A fifth intervention, Pager messaging, was selected to be updated to a mobile application. These adherence interventions showed efficacy in improving either medication adherence and/or viral load among either ART naïve or ART experienced patients. - See more at:

<http://www.effectiveinterventions.org/en/HighImpactPrevention/BiomedicalInterventions/MedicationAdherence.aspx#sthash.BQcQqQ4t.dpuf>



Of these four medication adherence interventions with e-learning trainings, the Department has approved three for implementation in Illinois. The fourth, Peer Support, is funded and coordinated by the Department's Ryan White Program as Peer Navigation Services and so will not be duplicated with Prevention funding.

## 1. HEART

- **Helping Enhance Adherence to Antiretroviral Therapy (HEART)** is a 5-session individual and dyadic-level intervention.
- This social support and problem-solving intervention includes 5 sessions and a patient-identified support partner. Two sessions are delivered just before initiating antiretroviral therapy and 3 sessions occur during the first two months after initiation of antiretroviral therapy. The first two sessions substitute for standard of care pre-medication adherence counseling. Participants are also contacted by phone between intervention sessions. The patient-identified support partner can attend all 5 sessions, but is required to attend at least 2 of the first 4 sessions, one of which needs to be a pre-medication session. Patients and support partners work through a series of problem-solving activities to identify and address adherence barriers. At each session, the person delivering HEART sessions follows a Semi-Structured Interview for Developing Medication Adherence Plans (SIDMAP) to review current circumstances and barriers, evaluate whether the strategies have been enacted and are working, generate new strategies if necessary, and update the list of barriers. HEART sessions are best delivered by a nurse, HIV case manager, or health educator with experience providing adherence counseling and education.
- Providers conducting HEART sessions with clients may include nurses, HIV case managers, health educators, licensed social workers and other professionals. All must have experience providing adherence counseling and education.
- A HEART e-learning module is available at:  
<https://effectiveinterventions.cdc.gov/en/TrainingCalendar/login?SessionID=2080&SessionTypeID=97&type=R>
- *Approved Target Population: Any HIV positive individual who is ART naïve or changing their ART regimen and willing to participate in the intervention.*

## 2. SMART Couples.

- **Sharing Medical Adherence Responsibilities Together (SMART Couples)** is a couple-level intervention administered to discordant couples that addresses adherence to ART and safe sex behaviors within the couple dyad, fostering active support of both individuals.
- Four 45-60 minute sessions over 5 weeks
- A SMART Couples e-learning module is available at:  
<https://effectiveinterventions.cdc.gov/en/TrainingCalendar/login?SessionID=2046&SessionTypeID=96&type=R>
- *Approved Target Population: HIV-discordant couples, with poor medication adherence in the HIV-positive partner*

### 3. Partnership for Health

- This intervention involves brief (3-5 minute), clinic-based individual-level, provider-administered sessions emphasizing the importance of the patient-provider relationship to promote patient's healthful behavior. The intervention includes adherence messages delivered to the patient during routine medical visits and the use of posters and brochures conveying the partnership theme and ART adherence messages.
- 3 to 5 minute sessions at each clinic visit
- Partnership for Health is designed to be conducted by nurses, HIV case managers, health educators, licensed social workers). (Add Link!) These persons should have experience providing adherence counseling and education.
- A Partnership for Health e-learning Module is available at:  
<https://effectiveinterventions.cdc.gov/en/TrainingCalendar/login?SessionID=2046&SessionTypeID=96&type=R>
- *Approved Target Population: Any HIV positive individual who is ART experienced.*

## C. Biomedical Risk Reduction interventions for High Risk Negatives

### 1. Non-Occupational Post-Exposure Prophylaxis (nPEP)

nPEP is a risk reduction method requiring a medical referral that may be offered for a client's consideration as individually appropriate during *any* public health strategy or risk reduction activity and documented as an activity and referral for that session. Non-occupational Post-exposure Prophylaxis (nPEP) is the provision of antiretroviral drugs to prevent HIV infection after unanticipated sexual or injection-drug-use exposure. The *U.S. Department of Health and Human Services (DHHS) Working Group on nPEP* made the following recommendations for the United States: For persons seeking care less than 72 hours after non-occupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person known to be HIV infected, when that exposure represents a substantial risk for transmission, a 28-day course of highly active antiretroviral therapy (HAART) is recommended. Antiretroviral medications should be initiated as soon as possible after exposure. For persons seeking care more than 72 hours after non-occupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person of unknown HIV status, when such exposure would represent a substantial risk for transmission if the source were HIV infected, no recommendations are made for the use of nPEP. Clinicians should evaluate risks and benefits of nPEP on a case-by-case basis. For persons with exposure histories that represent no substantial risk for HIV transmission or who seek care more than 72 hours after exposure, DHHS does not recommend the use of nPEP. Clinicians might consider prescribing nPEP for exposures conferring a serious risk for transmission, even if the person seeks care more than 72 hours after exposure if, in their judgment, the diminished potential benefit of nPEP outweighs the risks for transmission and adverse events. For all exposures, other health risks resulting from the exposure should be considered and prophylaxis administered when indicated. Risk-reduction counseling and indicated intervention services should be provided to reduce the risk for recurrent exposures. Source: <http://www.cdc.gov/mmwr/PDF/rr/rr5402.pdf>

### 2. Pre-Exposure Prophylaxis (PrEP)

PrEP is a risk reduction method option requiring a medical referral that may be offered for a client's consideration as individually appropriate during *any* public health strategy or risk

reduction activity and documented as an activity and referral for that session. Pre-Exposure Prophylaxis (PrEP) refers to a prophylactic drug taken to prevent disease. When a person takes a drug to prevent HIV infection, it is called HIV prophylaxis. With Post-Exposure Prophylaxis (PEP), HIV medications are started within 72 hours after the exposure to HIV to prevent infection. With PrEP, if a person is HIV-negative, Truvada is taken before possible exposure to HIV to prevent infection. Truvada is a combination of the drugs Emtriva and Viread. It was originally approved for treating HIV in 2004. Once it is decided that a client is a candidate for PrEP, further assessments are needed to clearly understand the prevention needs of the individual client and whether initiation of PrEP is an appropriate option.

The *IDPH PrEP Decision Counseling Guidance* provides detailed guidance on PrEP counseling, linkage and medical implementation.

# Targeted High Risk Populations and Approved Interventions

## MSM - Men Who Have Sex with Men

### **Population Definition:** HIV positive and HIV negative Men Who Have Sex with Men (MSM)

A high-risk MSM is defined as:

- Any male (including a transgender male) aged 12 years or older who has ever had anal sex with a male (including a transgender male).

The following risk subgroup is also prioritized but solely for Health Education/Risk Reduction services:

- A same sex attracted adolescent male (SSAAM) is a potentially high-risk MSM adolescent defined as any male (including any transgender male), age 13-19 years, who reports ever having had oral sex with a male (including a transgender male) or who states he is sexually attracted to males (including transgender males).

Note: **Transgender individuals** may be included within any priority population based on *personal risk history* and *current gender identification*. Gender reassignment surgery should not be assumed, and unless a transgender client opts to disclose an operative status, risk assessment should assess sexual risks inclusive of the possibilities for male and female anatomy. Transgender identity does not mean an individual engages in risk behaviors. Although Transgender identity is not considered a behavior risk priority population in and of itself, a specific section of interventions is included to guide service providers toward effective programming.

### **Key Public Health Strategies**

Comprehensive Risk Counseling Services	Partner Services (for CBOs)
Risk-Based HIV Testing and Referral (RBHTR) and Linkage to Care (LTC)	Partner Services (Health Departments)
Hepatitis A & B Vaccination	STI Screening (gonorrhea, Chlamydia, syphilis)
Human Papilloma Virus Vaccination	
Internet Risk Reduction Counseling (IRRC)	

### **CDC-Supported Interventions**

ARTAS (only for PLWH)

CLEAR (only for PWHIV)

Community PROMISE

d-up: Defend Yourself!

Healthy Relationships (only for PWHIV)

Many Men, Many Voices (3MV)

Medication Adherence (only for PLWH)

Mpowerment

Personal Cognitive Counseling (PCC) with RBHTR

Popular Opinion Leader (POL)

Project Start (only for PLWH)

**IMPORTANT:** *Please be sure to read the description of interventions listed at the back of this document thoroughly! The risks, ages, races and serostatus allowed for each intervention will be listed directly in the description.*

## HRH - High Risk Heterosexual

Population Definition: **HIV positive and HIV negative High Risk Heterosexuals (HRH)**

A High Risk Heterosexual (HRH) is defined as:

A male (including a transgender male) not meeting MSM definitions and a female (including a transgender female)

- (1) who does not meet the PWID definition, and
- (2) who has ever had vaginal or anal sex with someone of the other gender and
- (3) who also discloses meeting **one** of the criteria below:
  - Male or Female living with HIV Disease
  - Male or Female who has ever had vaginal or anal sex with an HIV positive partner of the other sex
  - Female (including a transgender female) who has ever had anal sex with a male

Note: **Transgender individuals** may be included within any priority population based on personal risk history and current gender identification. Gender reassignment surgery should not be assumed, and unless a transgender client opts to disclose an operative status, risk assessment should assess sexual risks inclusive of the possibilities for male and female anatomy. Transgender identity does not mean an individual engages in risk behaviors. Although Transgender identity is not considered a behavior risk priority population in and of itself, a specific section of interventions is included to guide service providers toward effective programming.

### Key Public Health Strategies

Comprehensive Risk Counseling Services	Partner Services (for CBOs)
Risk-Based HIV Testing and Referral (RBHTR) and Linkage to Care (LC)	Partner Services (Health Departments)
Hepatitis A & B Vaccination	STI Screening (gonorrhea, Chlamydia, syphilis)
Human Papilloma Virus Vaccination	
Internet Risk Reduction Counseling (IRRC)	

### CDC-Supported Interventions

ARTAS (HIV+ only)	Project Start (HIV+ only)
CLEAR (HIV+ only)	
Community PROMISE	Safe in the City
CONNECT (Serodiscordant couples)	Sister to Sister
Healthy Relationships (HIV+ only)	TWISTA (for TransWomen)
Medication Adherence (HIV+ only)	WILLOW (HIV+ only)

**IMPORTANT:** Please be sure to read the description of interventions listed at the back of this document thoroughly. The risks, ages, races and serostatus allowed for each intervention will be listed directly in the description.

## PWID- People Who Inject Drugs

### **Population Definition:** HIV positive and HIV negative People Who Inject Drugs

A high-risk person who injects drugs (PWID) is defined as a person of any gender who:

- does not meet the MSM definition and
- discloses ever injecting non-prescribed drugs

Note: **Transgender individuals** may be included within any priority population based on *personal risk history* and *current gender identification*. Gender reassignment surgery should not be assumed, and unless a transgender client opts to disclose an operative status, risk assessment should assess sexual risks inclusive of the possibilities for male and female anatomy. Transgender identity does not mean an individual engages in risk behaviors. Although Transgender identity is not considered a behavior risk priority population in and of itself, a specific section of interventions is included to guide service providers toward effective programming.

### **Key Public Health Strategies**

Comprehensive Risk Counseling Services	Harm Reduction/Syringe Exchange/Naloxone
Risk-Based HIV Testing and Referral (RBHTR) and Linkage to Care (LC)	Internet Risk Reduction Counseling (IRRC)
Group Prevention & Support (GPS)	Partner Services (for CBOs)
Hepatitis A & B Vaccination	Partner Services (Health Departments)
Human Papilloma Virus Vaccination	Risk Reduction Counseling (RRC)
Hepatitis C Testing	

### **CDC-Supported Interventions**

ARTAS (HIV+)

CLEAR (HIV+)

Community PROMISE

Healthy Relationships (HIV+)

Medication Adherence (HIV+)

Project START (HIV+)

Together Learning Choices

WILLOW

**IMPORTANT:** *Please be sure to read the description of interventions listed at the back of this document thoroughly. The risks, ages, races and serostatus allowed for each intervention will be listed directly in the description.*

## MSM/WID- Men Who Have Sex with Men Who Inject Drugs

**Population Definition:** A high risk HIV positive and HIV negative MSM/WID

A MSM/WID is defined as any male or transgender male who meets the definitions of both MSM and PWID who discloses:

- ever having anal sex with a male or transgender male, and
- ever injecting non-prescribed drugs

Note: **Transgender individuals** may be included within any priority population based on *personal risk history* and *current gender identification*. Gender reassignment surgery should not be assumed, and unless a transgender client opts to disclose an operative status, risk assessment should assess sexual risks inclusive of the possibilities for male and female anatomy.

Transgender identity does not mean an individual engages in risk behaviors. Although Transgender identity is not considered a behavior risk priority population in and of itself, a specific section of interventions is included to guide service providers toward effective programming.

### Key Public Health Strategies

Comprehensive Risk Counseling Services	Human Papilloma Virus Vaccination
Risk-Based HIV Testing and Referral (RBHTR) and Linkage to Care (LC)	Internet Risk Reduction Counseling (IRRC)
Harm Reduction/Syringe Exchange/Naloxone	Partner Services (for CBOs)
Hepatitis A & B Vaccination	Partner Services (Health Departments)
Hepatitis C Testing	

### CDC-Supported Interventions

All Public Health strategies and interventions approved for MSM or PWID populations are approved for MSM/WID.

# **Service Requirements and Performance Standards**

## **General Prevention Service Guidelines**

### **Performance Standards for All Risk-Based Interventions:**

- For risk-based grants, at least 75% of clients served in 2017 must disclose a risk prioritized in the *2017 Risk Group Definitions and Points of Consideration*. (See pages 10-11).

### **Agency Requirements for All Risk-Based interventions:**

Agencies providing HIV prevention services:

- Must include an approved recruitment component (outreach, social marketing, risk pre-screening, risk-peer social network recruitment, health communication/public information, internet, etc.) as a part of the intervention cost. Agencies conducting risk-based interventions must identify sites or targeting methods likely to reach high concentrations of the each specific Department-prioritized risk populations they apply to serve.
- Must ensure that all counselors conducting any HIV prevention intervention and all users of Provide® database have completed the Department's Confidentiality and Security Training, received a passing score on the training quiz, and taken the Confidentiality and Security oath within the past twelve months.
- Must ensure that counselors conducting any HIV prevention intervention have accurate knowledge about HIV transmission and risk reduction and have completed all Department-required training for the funded interventions.
- Must ensure their counselors provide services competently for a client's risk and culture.
- Must offer to clients as individually needed: condoms, lubricant safer injection equipment and referrals to healthcare and social services for biomedical risk reduction options and other needs related to their health, safety, and economic well-being.
- Must receive site authorization and a site number from the Department before delivering services at a new site.
- Are encouraged to develop for each service site a signed Memoranda of Understanding with any site-associated gatekeeper organization demonstrating the gatekeeper's agreement to HIV prevention service promotion or delivery on the premises
- Should preferably document referral collaborations with other service provider organizations in a Memoranda of Understanding to facilitate referrals and confirm referral use
- Must develop and maintain a Quality Assurance Manual including:
  - agency policies relevant to HIV prevention
  - agency protocols for all funded HIV prevention interventions
  - documentation of required training completion for any staff conducting any intervention with training requirements
  - Memoranda of Understanding with sites and referral services
  - Physician standing orders (if testing or vaccinating)
  - CLIA waivers (if using CLIA-waived test kits)



**Staff Requirements for All Risk-Based Interventions:**

HIV Prevention interventions funded by the Department shall only be provided by counselors who have successfully completed:

- Risk Reduction Counseling Training
- Confidentiality & Security Training, passing the test and submitting the oath *annually*.

**Documentation Requirements for All Risk-Based Interventions:**

- Providers must have Provide®-licensed and -trained staff members enter intervention sessions and referrals into the Department-approved secure data base. Providers must not permit unlicensed staff to use or enter data in Provide.
- Data for all interventions provided in a given month must be entered into Provide® service reports marked as completed (unless awaiting a confirmatory test result) by the fifteenth of the following month.

**Evaluation Requirements for All Risk-Based Interventions:**

Process Evaluation will be monitored through:

- Provide® Reports offering a comparison of service documentation entered into Provide® to contracted scopes of services for each intervention and targeted population.
- Quality Assurance observations of interventions being delivered (or role-played interventions in the case of Surveillance-based Services or Partner Services) assessing the fidelity to service standards of the service conducted biannually by IDPH grant monitors or lead agencies.

Outcome Evaluations may be monitored through:

- a comparison (baseline vs. most recent) of risk latencies (self-reported estimate of the length of time from the session date without an occurrence of the risk behavior) assessed during service delivery for clients served at least two times.
- a comparison of the frequency of reportable sexually transmitted disease diagnoses for an interval preceding the intervention with an interval of similar length following the intervention where client names are confidentially reported
- for prevention for negatives interventions, comparison of HIV antibody/antigen testing results on the session date to similar testing results at a follow up interval to determine whether any new HIV infections have occurred among clients who tested antigen/antibody-negative at the time of the intervention
- for prevention for positives interventions, comparison of “in treatment” status in the six months prior to the intervention with “in treatment” status in the six months following the intervention as evidenced by documentation of the dates of HIV medical laboratory tests
- for prevention for positives interventions, comparison of the most recent viral load level prior to the intervention with viral load levels conducted at least three months following the intervention.

## Risk-Based HIV Testing and Referral (RBHTR) Guidance

### RBHTR Performance Standards

- 100% of clients confidentially tested for HIV by a risk-based grant will sign a release authorizing the input of the testing record information into Provide® Enterprise for quality assurance review by IDPH and any designated Lead Agency of that region for the grant funding the testing activity and authorizing the Department's HIV Surveillance Unit to release to the testing agency dates of past HIV diagnosis and treatment to facilitate appropriate support for treatment linkage or reengagement.
- At least 1.0% of clients tested for HIV testing through this grant will be newly identified as HIV-positive (i.e. not previously reported as HIV-positive to IDPH HIV Surveillance).
- At least 90% of HIV tests with preliminary positive results will be documented in Provide® Enterprise as *confidential* tests with the required written client consent.
- At least 85% of persons who test preliminarily positive for HIV will receive their confirmatory test results.
- At least 80% of persons who receive their HIV preliminary positive test results will authorize transmission of their referral information to Ryan White Case Management services or medical primary care (referral) within 72 hours of receiving their confirmatory result and will attend their first HIV medical appointment (linkage) within one month of learning their preliminary positive results.
- At least 90% of persons who receive their HIV positive test results will be *offered* Partner Services
- At least 75% of persons who receive their HIV positive test results will *participate* in Partner Elicitation and individualized Partner Notification Planning.
- At least 90% of located *partners* elicited from HIV-positive clients identified by certified local health department HIV testing programs shall be offered partner counseling and referral services (PCRS).

### RBHTR Agency Requirements

All agencies funded to provide Risk-Based HIV testing and referral (RBHTR) services shall:

- Conduct this service according to current Department protocols, as outlined in the Department's HIV Prevention Counseling, Testing and Referral Guidance Manual.
- Ensure that all staff delivering RBHTR have completed all training requirements outlined below in *RBHTR Staff Requirements*.
- Ensure attendance of at least one agency staff member at any Risk-Based HIV Testing and Referral (RBHTR) updates offered by the Department and maintain documentation of that attendance.
- Obtain annually and maintain on file a Physician Standing Order from a licensed physician, specifying type of IDPH-approved specimen collected (venous blood, finger stick, or oral) and type of venue (street outreach, mobile, fixed site, etc.) where testing will be conducted.
- Obtain every two years and maintain on file a current CLIA Waiver for IDPH approved for HIV Rapid testing.
  - The CLIA Waiver application is on line **[www.cms.hhs.gov/clia](http://www.cms.hhs.gov/clia)**.
  - Click on "how to apply."
  - The IDPH CLIA Waiver Office at 217-782-6747 can also provide assistance.

- Maintain updated written protocols to provide HIV testing to prioritized risk clients.

### **RBHTR Staff Requirements**

All Risk-Based HIV Testing and Referral (RBHTR) and Partner Services (PS) shall be provided only by counselors who have successfully completed:

- IDPH HIV Prevention Home study course with a score of 80% or higher;
- An IDPH-approved Risk-Based HIV Testing and Referral (RBHTR) Course;
- IDPH Fundamentals II Partner Services (PS) training within 3 months of completion of Fundamentals I
- At least one HIV-related continuing education/skill development course each year with proof of completed course documented in the organization's Quality Assurance Manual.
- Confidentiality & Security Training, passing the test and submitting the oath *annually*.

### **RBHTR Service Delivery Requirements**

- Provide client-centered risk assessment, testing, partner services and Linkage to Treatment services using the protocol described in the US Centers for Disease Control and Prevention (CDC) guidelines, "Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing" ( <http://www.cdc.gov/hiv/testing/nonclinical/index.html>, March, 2016), and the Illinois HIV/AIDS Confidentiality and Testing Code.
- Offer HIV testing only to persons 12 years of age or older in accordance with limits on a minor's right to consent granted through the Illinois STD Control Act
- In accordance with FDA-approved kit instructions described in the package inserts,
  - offer OraQuick Advance testing only to persons 12 years and older.
  - offer Clearview testing only to persons 13 years and older.
  - offer Determine testing only to persons 12 years and older.
  - offer Orasure testing only to persons 13 years and older.
- Conduct test counseling sessions *individually* in a *private* setting where discussion cannot be overheard or interactions visually observed by others in the vicinity.
- Note that Prevention Counseling is ***no longer*** an integral part of Risk-Based HIV Testing and Referral (RBHTR). Delivery of other needed and approved prevention services should be documented as distinct service sessions.
- Include in the pre-test session discussion:
  - HIV transmission and the natural history of HIV infection,
  - the meaning and limitations of the test and test results,
  - the purpose and potential uses of the HIV test,
  - the statutory rights to anonymous testing and to confidentiality,
  - availability of additional or confirmatory testing,
  - the availability of referrals for further information, or counseling,
  - individually appropriate HIV risk reduction methods instruction, including demonstration of proper syringe cleaning, condom use and latex barrier use.
  - assessment of the client's ability to safely cope with a positive test result
  - assessment of the client's HIV exposure risk behaviors including partner risk,
- Use Department-provided rapid HIV test kits in accordance with Department protocols, current CDC guidelines, and FDA-approved manufacturer's package inserts.

- Use whole blood serum testing for conventional or confirmatory testing in accordance with Department protocols when provider capacity setting allows for sterile specimen collection and transport, and proper disposal of sharps or other bio-hazardous materials.
- Use Orasure conventional testing only for confirmation of rapid preliminary positive or rapid indeterminate results.
- Provide directly or offer referrals for syphilis and Mantoux tuberculosis (TB) testing for prioritized risk clients and document referral use
- Provide post-test counseling sessions privately, individually, and face-to-face for all persons who remain or return for their test results.
  - Inform clients of their results, their meaning and limitations.
  - Review the client's prevention plan and referrals offered.
  - Follow up to document referral services accessed.
- For clients with preliminary positive rapid HIV test results, complete the following steps.
  - Request a confirmation test specimen
  - Submit blood specimens to the IDPH laboratory; submit oral fluid specimens to a private laboratory
  - If a negative Orasure result follows a rapid test preliminary positive result, counsel the client that Orasure may not detect acute HIV infection, and facilitate the collection of a venous blood sample for laboratory antigen/antibody testing.
  - Request a written release to immediately submit their contact information and testing record information to the regional Ryan White Case Management Lead Agency or to a competent HIV primary medical care provider of their choice.
  - Note that Linkage to Treatment following a preliminary positive result is a part of Risk-Based HIV Testing and Referral (RBHTR) and requires no separate scopes of service. RBHTR service units awarded to an applicant agency include the requirement to initiate linkage to treatment when a preliminary positive result occurs.
  - Explain Partner Services options, and initiate a discussion to elicit potentially exposed sex or injecting partners who may need notification if the positive result is confirmed
- For clients with confirmed positive results, complete the following steps.
  - Review Partner Services options, and elicit potentially exposed sex or injecting partners who may need notification.
  - Develop a plan for the notification (client notification, public health notification, assisted notification or contractual notification) of each exposed partner
  - Document contact information for partner(s) elicited from persons testing positive in Provide for partner notification and follow up
  - Provide and document verbal explanation of Illinois law 720 ILCS 5/12 - 16.2 addressing criminal transmission of HIV.

### **RBHTR Documentation Requirements**

All agencies shall submit the following to the Department's HIV Testing Unit via the Provide® Enterprise system within the time frames specified:

- Electronic submission of required information from a completed Risk-Based HIV Testing and Referral (RBHTR) Report Form before the fifteenth day of the month following the month in which HIV testing was provided or if the client declined to be tested. (e.g., for all clients served in March, data must be submitted by April 15.)

- Document the referrals to Ryan White Case Management or HIV Treatment in Provide® Enterprise. Submit scanned viral loads in Provide as evidence of HIV treatment for clients referred directly to medical providers *outside* of the Ryan White program.
- Document anonymously tested client records using the Department's client code.
- Submit Partner Service information to Department's HIV Testing Unit through Provide.
- Out-of-jurisdiction exposed partner contacts should be forwarded to IDPH HIV Testing Unit.
- Submit the Initial Interview Record electronically for each client testing positive within ten working days of the actual or scheduled post-test counseling session, and a completed interview record, including all known partner dispositions documented, within 30 days after initial post-test counseling session.
- All testing providers are required by law to report a confidential (but not anonymous) HIV positive test result to the IDPH HIV Surveillance Unit on the IDPH HIV Case report form.

## **Partner Services (PS) Guidance**

Partner Services (PS) involves working with people with HIV disease (PWHIV) upon first diagnosis and on an ongoing basis as needed to elicit and then notify partners potentially exposed through unsafe sex or injection practices of their exposure to HIV, providing risk reduction counseling, HIV testing and referral to needed services.

- Testing-triggered PS is an integral component of the RBHTR intervention requiring no separate grant PS service objectives. RBHTR service units automatically include initiating PS for testing-identified PWHIV in adherence to Department RBHTR protocol and procedure manual.
- Surveillance-triggered PS is a stand-alone intervention for which Local Health Departments (LHDs) may request service objectives for partner elicitation and/or partner notification.

## **Partner Services Performance Standards**

- At least 50% of Partners named for public health notification will be notified by the Illinois LHD or Designated CBO with jurisdiction for the named partner's residence.
- At least 50% of notified Partners of unknown status will agree to Risk-Based HIV Testing and Referral (RBHTR).
- All Performance Standards for RBHTR apply to Partners tested through PS.

## **Partner Services Agency Requirements**

- Certified LHDs may provide all steps of partner elicitation and partner notification when either testing-triggered or surveillance-triggered.
- Community-Based Organizations may provide partner elicitation but may not provide direct notification of partners of HIV-positive person, unless officially designated by IDPH to do so.
- CBO's may be present as requested by an Index case PWHIV to support or facilitate the client's notification of a partner.
- CBO's should send paper field record referrals of exposed partners elicited during testing sessions to the LHD of the county where the testing session occurred.
- Local Health Departments should develop linkage agreements with local HIV health care providers and related support service agencies able to provide culturally- sensitive and risk-competent care and prevention services of PWHIV and their partners.

## **Partner Services Staff Requirements**

All HIV counselors providing Partner Services for Testing must meet the following training requirements:

- Completion of the IDPH HIV Prevention Home Study course with a score of 80% or higher;
- Completion of the Risk-Based HIV Testing and Referral (RBHTR) course
- Assignment by IDPH of an RBHTR counselor number;
- Completion of the Fundamentals II, Partner Services training within 3 months of the Risk-Based HIV Testing and Referral (RBHTR) training offered by the Department.
- Confidentiality & Security Training, passing the test and submitting the oath *annually*.

## **Partner Services Delivery Requirements**

- IDPH will refer to LHDs HIV disease cases residing within their jurisdictions which were reported to IDPH HIV Surveillance by physicians, hospitals, laboratories and other health facilities as required by State law. LHD staff will then conduct follow-up with the HIV-positive person to provide partner services, risk reduction counseling and referrals to medical and support services.
- IDPH will also refer to LHDs elicited, exposed partners residing within their jurisdictions reported to the IDPH HIV Partner Services Coordinator on paper or electronic field records.
- Local Health Departments applying to conduct surveillance-based PS should request sufficient service units to include both sessions with PWHIV (for partner elicitation) and sessions with partners (for exposure notification, testing, and risk reduction counseling, and referrals).

## **Documentation Requirements**

- Electronic field records should be generated in Provide for each partner named by either a newly HIV diagnosed testing client or by a surveillance- reported PWHIV,
- Grant-funded PS providers should assign staff licensed and trained in using the Provide® data management system with up-to-date annual Confidentiality and Security training to enter partner service data triggered by testing or surveillance.

## **Surveillance-Based Services**

In Surveillance-Based Services, the Department securely refers through Provide Enterprise cases of persons living with HIV Disease whose diagnoses have been reported to HIV Surveillance to an organization authorized by statute or designation to provide services to them. An HIV counselor or epidemiologist then contacts the person to:

- (1) identify unmet needs for HIV serostatus notification, HIV primary medical care, medication coverage assistance, HIV case management, medication adherence counseling, effective risk reduction interventions, partner services, other social services, and sexual or injection risk reduction supplies.
- (2) notify the uninformed individual of their diagnosis
- (3) securely link the person to individually appropriate medical care and support services
- (4) provide effective medication adherence intervention
- (4) assist the person to develop a personal, realistic HIV transmission risk reduction plan,
- (5) voluntarily elicit the names and contact information of potentially exposed sex or injection drug partners, and
- (5) support the client to voluntarily develop and implement a plan to inform each partner that they may have been exposed to HIV.

Case information documented in these encounters strengthens the accuracy and completeness of Department HIV surveillance records.

Specific details regarding authority, processes, documentation and other requirements are described in the IDPH HIV Prevention Unit “Surveillance Based Services Protocol”.

Linkage to Treatment with Adherence Counseling is a highly effective and cost effective biomedical prevention-for-positives strategies sometimes called “treatment as prevention.”

According to the CDC:

“Treating people living with HIV early in their infection dramatically reduces the risk of transmitting the virus to others, underscoring the importance of HIV testing and access to medical care and treatment. A recent clinical trial showed that treating people living with HIV early on reduces the risk of transmitting the virus to others by 96 percent.”

## **Surveillance-Based Services Performance Standards**

- At least 90% of surveillance-reported PWHIV cases referred by the Department through Provide® to Local Health Departments (LHD) or Designated Community-Based Organizations (DCBO) for Surveillance-based Services (i.e. SBS Cases) will be acknowledged and fully investigated by the provider.
- At least 30% of investigated SBS Cases will be located and successfully contacted.
- At least 70% of contacted cases will accept service.
- At least 40% of cases accepting service will participate in a Behavioral Risk Reduction Intervention.
- At least 50% of cases agreeing to service who upon contact were not taking ARVs will complete a Medication Adherence intervention.



- At least 95% of cases accepting service will be asked about at-risk partners.
- At least 30% of cases asked about at-risk partners will acknowledge at least one at risk partner.
- On average per case, at least 0.25 exposed partners needing notification will be elicited.
- At least 80% of cases accepting service who are not currently in HIV medical treatment will complete a first HIV medical care visit resulting in a Viral Load or CD4 count being reported to IDPH HIV Surveillance within 1 months of first contact.

### **Surveillance-Based Service Agency Requirements**

- Based on legal statutes, Surveillance-Based Services may be provided by Local Health Departments. Community-Based Organizations officially designated by IDPH to do so may also provide Surveillance-Based Services.

### **Surveillance-Based Service Staff Requirements**

All Counselors providing SBS must meet the following training requirements:

- Confidentiality & Security Training, passing the test and submitting the oath *annually*.
- Surveillance-Based Services Protocol Training
- Risk Reduction Counseling Training
- Fundamentals of Prevention Counseling, Part I and Part II
- Adherence Counseling Training including review of current FDA-approved Anti-retroviral therapies, their side effects, and methods to improve their tolerance.
- Training in HIV Disease Progression and its clinical laboratory markers
- Optional: ARTAS (Anti-Retroviral Therapy and Access to Services) training
- Optional: Individual-Level CDC-supported Diffused Effective Behavioral Intervention for PWHIV such as CLEAR
- Staff assigned to enter data in Provide® are required to be licensed and to receive training in Provide®

### **Surveillance-Based Service Delivery Requirements**

This form of LTT/AC will follow the protocol below:

- IDPH Surveillance will identify PWHIV with no indication of care in the past 12 months and refer these cases to funded LHD with trained Disease Intervention Staff (DIS) staff.
- Out of care PWHIV will be defined as individuals reported with HIV disease for whom:
  - no reported clinical laboratory VL or CD4 tests have been received by IDPH Surveillance for the past 12 months
  - Ryan White Case Management enrollment is expired or never occurred
  - ADAP and CHIC enrollment are expired or never occurred
- LHD through their DIS staff will contact these out of care individuals to:
  - Assess their current care and prevention needs by conducting a Risk and Needs assessment inventory
  - Identify any barriers to access to care
  - Link consenting individuals to medical care and HIV Case Management
  - Monitor or assist to ensure that consenting client attends to 1<sup>st</sup> appointment of medical care and HIV Case Management

- Conduct adherence counseling to increase the probability of successful treatment adherence
- Deliver individual risk reduction counseling where appropriate using the Fundamentals of HIV Prevention Counseling model or DEBIs prioritized for PWHIV and individually risk appropriate
- Assess whether the client or their partner is pregnant and refer the woman to PACPI

### **Documentation Requirements**

- Submit Surveillance-based Service data through the Provide® Surveillance-based Services input screens, recording session data and updated client information into Provide® by the 15<sup>th</sup> of the following month.

## Risk Reduction Activities (RRA) Guidance

Risk Reduction Activities include (1) Behavioral Interventions to reduce HIV/STI/Viral Hepatitis exposure risk behaviors, (2) Biomedical Interventions to reduce HIV infections from HIV exposures and (3) Integrated Prevention Services such as Sexually Transmitted Infection or Viral Hepatitis Risk-Based screenings and vaccinations to reduce risk through reduced HIV-infectivity of HIV-negative individuals and HIV infectiousness of HIV-infected individuals. Please refer to <https://www.effectiveinterventions.org/en/Home.aspx> for details regarding specific interventions.

### RRA Performance Standards

- 75% of RRA service units (person-sessions) will be conducted with persons with prioritized risk histories.
- 100% of clients receiving RRA who report a previous HIV-positive result and no visit to a physician within the past 12 months will be offered a referral to an HIV Medical Care provider. The provider will document in Provide under session referrals and attendance of a first Medical Care appointment shall be documented as a Medical Care accessed in Provide under session referrals.
- 100 % HIV+ clients served with Individual Level RRA shall be offered Partner Services by the counselor. Partners elicited shall be reported to the department on field records.
- No individual counselor shall report more than 2 Individual RRA sessions (excepting Harm Reduction Counseling) per hour worked.

### RRA Agency Requirements

- Agencies conducting RRA interventions for HIV-positive or HIV-negative persons with prioritized risk must meet *all* of the *General Prevention Service Guidelines* on pages 30-31.
- Agencies must request *separate* scopes of services for *HIV-positive* and *HIV-negative* persons (i.e. even if they will participate together in the same intervention) to ensure that sufficient percentage of risk reduction resources reach HIV-positive individuals to comply with new 2012 CDC guidelines.

### RRA Staff Requirements

All staff conducting RRA interventions must have:

- Confidentiality & Security Training, passing the test and submitting the oath annually
- Completed the HIV Prevention Home Study Course with a test score of 80% or higher.
- Completed the IDPH HIV/STD Risk Reduction Counseling training
- Completed the CDC-approved training for all DEBI's with schedules listed on [www.effectiveinterventions.org](http://www.effectiveinterventions.org).
  - **Note:** Prior to registering and attending out-of-state training, grantees should check with IDPH staff about potential upcoming DEBI training in Illinois. ***Out-of-state travel must be approved by IDPH prior to a grantee attending the training.***
  - Grantees should be prepared to budget not only travel costs to attend a particular DEBI training, but assess the agency's capacity and assure adequate budget to implement the intervention.

- Completed the IDPH STD Section online training to perform GC/CT urine testing.
- Completed the IDPH STD Section STI Prevention Counseling Webinar to conduct Risk-Based HCV, Syphilis and GC/CT screenings with prioritized populations.
- An MD, NP, PA, RN license in order to administer Hepatitis A&B or HPV Vaccinations. A copy of this license must be provided to the Grant Monitor or Lead Agent for each staff delivering this strategy.

## **RRA Service Delivery Requirements**

- Agencies conducting RRA interventions for HIV-positive or HIV-negative persons with prioritized risk must meet all of the *General Prevention Service Guidelines* Intervention Requirements above.
- All agencies funded to conduct a CDC-Supported Risk Reduction intervention (DEBI or locally developed Risk Reduction intervention) must also provide approved public health strategies (RBHTR, CRCS, STI screenings and vaccinations, Partner Services) directly or through referral to clients receiving the interventions who also need the strategy service(s).
- Awards for PWID prevention services will prioritize agencies which directly conduct comprehensive syringe exchange programs onsite or which partner an agency which provides such collocated services.
- Effective Behavioral Interventions (<https://www.effectiveinterventions.org/>) must be implemented with all their core elements and utilizing the most current curriculum available.
- **Adapting DEBIs to new risk populations:** When Diffused Effective Behavioral Interventions must be adapted to meet the needs of new risk populations or new venue types (i.e., not included in the efficacy studies):
  - CDC guidance requires the following formative program evaluation procedures:
    - Identify intervention components that need adaptation.
    - Collect information to form the procedures and materials.
    - Test the procedures and materials.
    - Document revisions and the data-basis of the revisions.
    - Implement, monitor, and evaluate the revised intervention;
    - Revise implementation materials, as needed.
  - Providers approved to conduct an adaptation of a DEBI must provide the IDPH and where applicable the Lead Agent with a report summarizing the formative and outcome evaluation of the intervention adaptation.
  - Adaptations must maintain the internal logic of intervention's core elements while ensuring cultural relevance and effectiveness for the new population.
  - Intervention specific adaptation must identify the health needs of the persons targeted, as well as their cultural needs and experiences to develop culturally and linguistically appropriate services. Intervention-specific adaptation must competently address the cultural experience of the persons targeted.
  - Intervention specific adaptation must adhere to the Department of Health and Human Service' Office of Minority Health (OMH) published national standards for delivering services that reflect a group's culture and language. This is referred to as culturally and linguistically appropriate services (CLAS). These standards can be accessed at <https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>.

- Interventions adapted to target bisexual men of color must adhere to the CDC adaptation guide, *Adapting HIV behavior change interventions for Gay and Bisexual Latino and Black Men*.
- Condom distribution to HIV-positives and those at high risk of infection is a highly recommended structural intervention. Condom distribution **must** be accompanied by counseling and/or education or incorporated as an element of an approved behavioral intervention.
- **Integrated Sexually Transmitted Disease or Viral Hepatitis Prevention Interventions**
  - **Integrated HCV Prevention**
    - Rapid HCV test kits for finger-stick whole blood specimens are available through the Department grantee agencies approved by the Department to conduct this RRA activity.
    - Rapid HCV test kits require a Physician's Standing Order less than 12 months old and a CLIA waiver for Rapid HCV Testing.
    - Conventional Hepatitis C testing for phlebotomy serum specimens, though approved for some populations, is no longer supported by the IDPH laboratory. Agencies wishing to conduct this screening will need to contract for laboratory services and obtain a Physician's Standing Order.
    - Clients testing positive for HCV by rapid or conventional test should be referred to a physician for clinical evaluation.
  - **Integrated Syphilis Prevention**
    - Outreach Targeted Syphilis Screening whether conducted by laboratory processing of venipuncture serum specimen or via an FDA-approved, CLIA-waived new rapid test using finger-stick whole blood specimens requires a Physician's Standing Order less than 12 months old.
  - **Integrated Chlamydia and Gonorrhea Prevention**
    - For Prioritized Risk Group Targeted Outreach Chlamydia/Gonorrhea Urine Screenings
      - Female must have Prioritized Risk and must be:
        - 25 years old or younger if sexually active
        - 26 years old w/ 1 or more of the following risks:
          - STD signs or symptoms
          - Vaginal discharge
          - Mucopurulent cervicitis (inflammation of the cervix due to infection)
          - Pelvic pain or suspected pelvic inflammatory disease
          - Sex partner of individual diagnosed with Chlamydia and/or gonorrhea
          - High risk sex partner
          - New sex partner in past 3 months
          - More than 1 sex partner in past 3 months
          - STD Diagnosis/History in the past 3 years
          - Pregnant
          - IUD insertion
      - Male with PCPG-prioritized risk must be:
        - 25 years old or younger if sexually active
        - 26 years old with one or more of the following risks:
          - STD signs or symptoms
          - Urethral discharge

- Dysuria
  - Sex partner of individual diagnosed with Chlamydia and/or gonorrhea
- If infected with Chlamydia and/or gonorrhea
  - report case to Local Health Department or IDPH STD Surveillance
  - link client to STD treatment
  - re- screen infected three months after treatment to detect re-infection
- 3% positivity rate is needed to maintain STD Section approval for this screening

### **RRA Documentation Requirements**

- Submit RRA Service data through the Provide® input screens, recording session data and updated client information into Provide® by the 15<sup>th</sup> of the following month.
- In order to document Hepatitis A&B Vaccinations in Provide a copy of the staff's MD, NP, PA, RN license must be provided to the IDPH HIV Data Unit to authorize entry of this intervention by that staff person.

## **Provider Responsibilities**

### **In planning for future services, providers must:**

- assess target population community needs and, identify recruitment strategies (outreach, social marketing, social networking, health communication/public information, Internet, etc.) which will engage adequate numbers of the target population as clients.
- document in their application to the Department or Lead Agent their fiscal and organizational capacity to administer and implement all proposed interventions. Grant applicants should identify staff training completed, training needs, and upcoming available training schedules to document preparedness to deliver the intervention within the project period.
- plan for the post-grant sustainability of the intervention given other potential internal and/or external sources of support including insurance billing.

### **In setting up services, providers must:**

- Negotiate scopes of services that are clearly distinguishable from services funded through other local, state, or federal government funds or private funds.
- Submit correct/current contact information of staff providing services to the Grant Monitor or Lead Agent.
- Submit a proposed budget focused on the costs of efficiently delivering the requested service units in a culturally and technically competent manner. All proposed expenses must comply with all applicable federal and state laws including the following.
  - Federal funds may not be used to purchase syringes for injection harm reduction syringe services.
  - Illinois General Revenue Funds may not be used to purchase promotional items including monetary or non-monetary incentives to receive a prevention service.
- Ensure that all project staff members have regular access to email and to a computer with word processor software able to import and export Microsoft Word files and a spreadsheet program able to import and export Microsoft Excel files.
- Refrain from utilizing a subcontractor to fulfill any obligations without the prior written consent of the Department and where applicable the Lead Agency.

### **In service provision, providers must:**

- Ensure that all services funded through this service agreement are provided in a manner that is confidential, culturally competent, and appropriate with respect to HIV risk, language, gender, literacy level and ability.
- Ensure that staff members conduct themselves in a professional manner while providing services under the context of this grant agreement.
- Ensure that all staff members refrain from using alcohol, illicit drugs, or being under the influence of alcohol or illicit drugs while providing any and all services under this grant.
- Adhere to HIPAA and AIDS Confidentiality Act to protect the confidentiality of information reported by HIV prevention recipients, including but not limited to substance use history, sexual history, HIV status, history of STD or other medical diagnoses.

- Maintain signed documentation of collaborative agreements between sites of HIV prevention outreach locations such as nightclubs, infectious disease clinics, methadone clinics, soup kitchens, businesses, etc.
- Immediately place a notice on any applicable website, prominently displayed on the web page(s) most likely to be first encountered by viewers, notifying the potential viewing public that “this site contains HIV prevention messages that may not be appropriate for all audiences.” This CDC requirement applies to those recipient web sites funded in whole or part with CDC funds that contain HIV educational information subject to the CDC guidelines, even if the website itself is not funded by CDC. The complete guidelines are available from the CDC website at [www.cdc.gov/od/pgo/forminfo.htm](http://www.cdc.gov/od/pgo/forminfo.htm).
- Submit all materials for publication for approval by the Regional Community Review Panel (RCRPA) or the Department’s community review panel prior to printing, broadcast, or publication. Upon approval from the RCRP or IDPH community review panel, all brochures, booklets, flyers, journal articles, programs, advertisements (including print and out-of-home), multimedia presentations, videos, and other printed or electronic materials (including, but not limited to web sites), prepared with funds from this grant/contract must include the following statement: Funding for this (event, publication, etc.) was made possible by funds received from the Office of Health Protection, Illinois Department of Public Health.
- Deliver interventions as outlined in the agency’s work plan, targeting services provided under this grant for promoting and providing HIV prevention services to HIV+ persons and persons at increased risk, defined as MSM (Men who have Sex with Men), HRH (female and male heterosexuals with high-risk behavior or high risk sexual partners), PWID (female and male People Who Inject Drugs) and MSM/WID (males with both MSM and PWID risk history) and as specified in their current work plans

**In reporting, providers must:**

- Report data on delivered HIV prevention interventions using the Department’s Provide® Enterprise system. Data for all RBHTR and RRA interventions shall be entered to the Provide® Enterprise system by the fifteenth day of the month following the month in which services were provided, (e.g., for all clients served in March, data must be submitted by April fifteenth).
- Submit quarterly reporting to the IDPH Grant Monitor or Lead Agency using the “quarterly report” form and schedule as provided by the Grant Monitor or Lead Agency.

**In assuring quality, providers must:**

- Require Program managers to attend all of the required biannual site visits and intervention observations scheduled by the IDPH Grant Monitor or Lead Agency.

**In planning and coordination efforts, providers must:**

- Participate in planning and assessment activities as required by the Department including but not limited to regional needs assessments and resource inventory data collection for the Illinois HIV Planning Group.
- Attend monthly or quarterly grantee meetings facilitated by the IDPH Grant Monitor or the Lead Agency Coordinator.



- Participate in local community forum, focus group, community assessment and community planning activities, as requested by the HIV Section and/or the Lead Agency Coordinator.

**In billing, providers must:**

- Expend moneys according to the funding level specified in the budget for each line item.
- Request reimbursement from the HIV Section or Lead Agency in accordance with provided instructions and forms and in adherence to the approved current grant or subgrant budget.
- Generate monthly billing by the deadlines stated in the grant agreement using Provide Enterprise® Contract Management system.

## **Appendix I: Overview of IDPH HIV Prevention Grants and Contracts**

### **African American AIDS Response Grants**

These grants are made from an Illinois State Treasury special fund to prevent HIV transmission, ensure prompt, quality HIV treatment and develop fiscally independent HIV services within African American communities to reduce HIV disease disparities between African-Americans and other racial groups in Illinois.

#### *Additional AAARA Applicant Eligibility Criteria:*

- The majority of members of the applicant's Board of Directors must be African-American.
- Applicants must provide services to individuals or families impacted by HIV.
- Applicants must be physically located within the community to be served.
- Applicants must provide HIV prevention and/or treatment services in predominantly African-American communities.
- Applicants must be in existence for at minimum one year prior to applying for a grant award from this fund.

### **Category B Billing Capacity Building Project for Routine HIV Testing Providers**

This project builds capacity among routine HIV testing providers including health care providers and local health department STD clinics to bill 3<sup>rd</sup> Party Payers (Medicaid, Medicare and Private Insurance) for Routine HIV Testing and positive follow up services. Assistance includes implementation of electronic medical records integrated with revenue management software, linkages to billing organizations, assistance with Medicaid and private insurance certification and with renegotiation of bundled, capitated service rates. The project encourages HIV healthcare screening providers to leverage other payer sources to cover the costs of HIV screening, thereby freeing up funding to support other HIV prevention projects. These activities are supported as part of the changing landscape with the Affordable Care Act.

### **Fetal Infant Mortality Review for HIV and Syphilis Exposures**

By reviewing detailed case information on specific pregnancies of Illinois women living with HIV and/or Syphilis infections, the systems resulting in a perinatal HIV and Syphilis exposures or transmissions are analyzed to identify system strengths, missed opportunities for prevention and the rare failures of interventions to prevent perinatal transmission. Recommendations are developed for improvements to Illinois systems of care for women with HIV and/or Syphilis infections and their infants.

### **Illinois General Revenue Fund HIV Prevention Grants**

HIV Prevention Grants supported by Illinois General Revenue Funds allocated to the IDPH HIV/AIDS Section may fund proposals for a variety of HIV prevention services for HIV-positive, HIV-negative persons with prioritized high risks for HIV infection, and at-risk populations. Individual requests for applications may target specific service needs.

## **Illinois Perinatal HIV Hotline**

This legislatively mandated hotline receives reports from health care facilities of all preliminary HIV-positive pregnant women and HIV-exposed newborns. The Hotline serves as a statewide resource for up-to-date treatment recommendations for providers and links mothers and their infants to care and enhanced case management services both during and after pregnancy.

## **Pediatric HIV Exposure Reporting System**

This contract ensures the collection of required Pediatric HIV Exposure Reporting variables abstracted from the medical records of HIV exposed infants.

## **Perinatal Routine HIV Screening and Enhanced HIV Case Management**

This grant funds an agency to ensure first trimester HIV testing of all Illinois pregnant women or their infants and to link HIV-positive pregnant women and new mothers to specialized case management services to ensure prenatal and postpartum maternal HIV care towards avoid perinatal HIV infections.

## **Quality of Life**

The Quality of Life Endowment Fund was created as a special fund in the Illinois State Treasury. The net revenue from the Quality of Life special instant scratch-off game is deposited into the Fund for appropriation by the Illinois General Assembly solely to the Illinois Department of Public Health (IDPH) to support grants for HIV prevention education to those at highest risk for HIV infection and disease progression. Grants are targeted to serve at-risk populations in proportion to the distribution of recently reported Illinois HIV Disease cases among risk groups as reported by the Illinois Department of Public Health. To be eligible, recipient organizations must be engaged in HIV prevention education or HIV healthcare treatment and supportive services. The grant funds may not be used for institutional or organizational overhead costs, indirect costs, or levies.

## **Regional HIV Prevention Grant**

Illinois HIV Prevention Regional Grant funds are contracted to lead agencies chosen to fund and monitor sub grantees to implement Regional HIV prevention service plans for prioritized highest risk Illinois residents in each region except Region 9, the City of Chicago. (The CDC directly funds the Chicago Department of Public Health to provide HIV Prevention services in Region 9). IDPH selected HIV Prevention Regional Grant Lead Agencies for Regions 1 through 8 through a competitive application process in December 2011.

Regional Service plans have been developed to ensure that in Regions 1-8 as a whole, within each region, and in each service class, service units are distributed by target population so that:

- Prevention service resources are distributed between regions proportionately to recent case distribution between those regions
- service class proportions conform to CDC grant guidelines for required versus recommended activities
- service units are distributed within regions based upon a gap analysis of other HIV prevention services in accordance to CDC grant guidelines

- service units are distributed to prioritized populations by risk by race/ethnicity so that the overall services delivered (for this grant plus others) in the region will be proportionate to recent HIV case regional distribution between those risk groups.

Funds are allocated among Regions by a weighted epidemiologic composite of 70% Incident HIV cases and 30% Prevalent HIV cases, a formula recommended by the Illinois HIV Prevention Community Planning Group to ensure close correspondence between its priorities and resource allocation.

Regional Gap Analysis seeks to identify in each region those prioritized populations recently *underserved* relative to epidemiologic proportions by HIV prevention services funded by any funding source *other* than the Regional Grant (RG) for which recent service data is available. It then identifies the numbers of RG service units needed to bring the proportion of *total* services (i.e. for all grants combined including RG) delivered to a given prioritized population into alignment with its proportion of the epi. Each RG funding cycle will adjust the recent service profile of other grant streams towards an overall epidemiologically proportioned total.

*Additional Applicant Eligibility Criteria for Regional Grants:*

- Organizations may apply to provide services outside of the Illinois Region in which they are based (e.g., an agency based in Region 9, Chicago could apply for Region 8 funds to provide services at Region 8 locations.) However, lead agencies may take into account the travel cost (e.g., staff time and mileage, etc.) if two agencies with an equal likelihood of engaging and effectively serving a prioritized population will have markedly different travel costs.
- Organizations may apply to deliver services in more than one region.
- Organizations should generally apply to serve sites within the geographic boundaries of the region for which funded was awarded. Exceptions may be made for a provider to cross regional boundaries to promote or provide a service at a nearby site in a neighboring region with advanced written approval from Lead Agencies of both regions. This boundary crossing may occur if no other funded providers serve that site and the site is the most efficient means of reaching a target population residing in the funding region. (Example: A Region 6 applicant located near the Region 7 border may propose to conduct HIV Test Counseling at a nearby Region 7 Methadone Clinic not served by other providers because 80% of the clinic's recently injecting clients actually live in Region 6. Prior to awarding Region 6 funds to serve this Region 7 site, the Region 6 Lead Agent would need approval in writing from the Region 7 Lead Agent. )